OPEN LETTER AND NOTICE OF LIABILITY FROM DOCTORS AND SCIENTISTS TO THE EMA AND THE MEMBERS OF THE EUROPEAN PARLIAMENT REGARDING COVID-19 VACCINATION

<<Name>>

September 13, 2021

This Notice of Liability has been SERVED to you personally.

In March 2021, we alerted you and the world to the fact that the approval of the so-called gene-based COVID-19 vaccines was premature and reckless, and that their administration constituted human experimentation in violation of the Nuremberg Code. Our concerns regarding the potential dangers of experimental agents were founded on common textbook knowledge of immunobiology and medicine. Simple reasoning led to the foresight that administration of the agents would incur multifaceted pathological events leading, among others, to life-threatening thromboembolic events. You were called upon to suspend the vaccination program until these concerns had been tended to in a satisfactory manner.

This request was scorned and the vaccination program has been rolled out on a global scale, with catastrophic consequences that we trust are known to you. Our original fears have been confirmed and further pathways leading to injury and death by the experimental agents have been uncovered through new scientific discoveries in 2021. The rush to vaccinate first and research later has left you in a position whereby COVID-19 vaccination policy is now entirely divorced from the relevant evidence-base.

The current state-of-the-tragedy is summarized in the appended document.

As you consider your next steps in mandating a vaccine that is contra-indicated by science, we draw your attention to recently published Freedom of Information requests, which reveal gross negligence in the COVID vaccine authorisation process, including misleading the Commission on Human Medicines as to whether any independent verification of vaccine trial data had occurred.

Hapless and defenceless children are now becoming victims of the blasphemic and negligently regulated vaccination agenda. We charge you for actively or tacitly paving the way to the second holocaust of mankind. The same charge has been independently submitted by survivors of the first holocaust and their families.

You are hereby placed on notice that you stand to be held personally and individually responsible for causing foreseeable and preventable harm and death from COVID-19 vaccines, and for supporting crimes against humanity, defined as acts that are purposely committed as part of a widespread or systematic policy, directed against civilians, committed in furtherance of state policy.

The gravity of your deeds is now laid out before the world. For the sake of yourselves and your families, rise and respond. Or go down in history books in indelible shame and disgrace.

Signed,
Doctors for Covid Ethics

Cc: Rechtsanwaltskanzlei Dr. Reiner Fuellmich

The Dangers of Covid-19 Booster Shots and Vaccines: Boosting Blood Clots and Leaky Vessels

New discoveries in the immunology of SARS-CoV-2 and COVID-19 vaccines

1. Summary: Are COVID vaccines and booster shots safe and necessary? New discoveries in SARS-CoV-2 immunity and vaccine-immune interactions.
2. In Full: Explanation of new findings on the immunology of COVID-19 and its vaccines: How and why Covid-19 vaccines incite immunological attack on blood vessel walls. What is wrong with booster shots?
3. Implications for doctors and patients.

1. Summary: Are COVID Booster Shots and Vaccines Safe and Necessary? New Discoveries in SARS-CoV-2 Immunity and Vaccine-Immune Interactions

By now, most people have heard that COVID-19 vaccines can cause blood clotting and bleeding. Some readers may even be aware that reports of death following COVID-19 vaccination outnumber those for all vaccines combined since records began, 31 years ago, in the official US database VAERS [1,2].

With many patients now having received their first and second doses of COVID-19 vaccines, additional booster shots are being rolled out in many countries. Given that no clinical trials have been performed on more than two injections of any vaccine, it is important that doctors and patients understand how the vaccines interact with the immune system, and the implications for booster shots.

So far, doctors and patients confronted with information on COVID vaccine side effects are typically reassured that the benefits of COVID-19 vaccination outweigh the risks. Governments, the pharmaceutical industry, regulators and the media advise populations that the majority of adverse events are mild and transient, with serious complications in only a small minority of vaccine recipients.

Most patients, however, are unaware that among relevant scientific experts such a view is not so readily shared. Eminent independent scientists and researchers in the fields of immunology and microbiology have been writing to medical regulators since early 2021 [3], warning of vaccine-related blood clotting and bleeding, including that the official data on blood abnormalities post-vaccination likely represent “just the tip of a huge iceberg” [4]. Those scientists’ warnings pre-dated vaccine suspensions around the world due to acute disease from aberrant blood clotting post-vaccination. The warnings were based on established immunological science, applied to the novel mechanism of action of the gene-based COVID-19 vaccines.

Now, more than six months later, new discoveries in the immunology of SARS-CoV-2 [5] have caught up with the rushed vaccination schedule, confirming and extending the experts’ prior warnings. The good news is that we are more comprehensively protected against COVID-19 by our own pre-existing immunity than was previously understood. On the other hand, this pre-existing immunity aggravates the risk that COVID-19 vaccines will induce blood clotting and/or leaky blood vessels. This risk must be expected to escalate with each revaccination. Vaccine-induced harm to our blood vessels is unlikely to be rare.

Perhaps the most pertinent finding is that, due to the discovery of a widespread memory-type antibody response to SARS-CoV-2, the antibodies induced by the COVID-19 vaccines can be expected to activate the so-called complement system. This can bring about the destruction of any cell that manufactures the SARS-CoV-2 spike protein, particularly in the circulation. If that happens to the endothelia, that is, the cell layer that lines the inner surfaces of our blood vessels, then those vessels may begin to leak [6] and clots will form. Given that 2021 research showed the spike protein to enter the bloodstream shortly after vaccination [5], this dangerous endothelial involvement in spike-production is highly likely, and should be expected to occur.

As stark as these medical realities may be, the silver lining is that the same antibody profile, along with previously documented T-cell immunity [7–11], protects around 99% of the population against life-threatening SARS-CoV-2 infections. This ties in with the known fact that over 99% of people are safe from death with COVID-19 [12–14]. The implications for doctors and patients are that:

1. Vaccination against COVID-19 is unnecessary. Populations are protected by their immune systems against COVID-19. This applies to SARS-CoV-2 in all its variants.
2. Booster shots are uniquely dangerous, in a way that is unprecedented in the history of vaccines. This is because repeatedly boosting the immune response will repeatedly boost the intensity of self-to-self attack.

An important consideration for patients is that those who have already been vaccinated against COVID-19, and whose health remains intact, can protect themselves against serious harm by stopping now.

For a detailed explanation of the science behind these vaccine-immune interactions, please read Part II. Implications for doctors and patients are considered in Part III.

2. In Full: Explanation of New Findings on the Immunology of SARS-CoV-2 and COVID-19 Vaccines

2.1. How and why COVID-19 vaccines incite immunological attack on blood vessel walls. What is wrong with booster shots?

Until recently, the immune profile of COVID-19 and COVID-19 vaccines was not fully characterised. While we have known since mid-2020 that robust and lasting memory T-cell immunity to SARS-CoV-2 exists [7–11], the antibody picture has been less clear. Now, however, a convergence of evidence from peer reviewed studies published in 2021 reveals that pre-existing immunity to SARS-CoV-2 involves not only T-cells but also memory antibodies, in 99% of people studied. Two publications from 2020 alert to the probability that the immune response to the vaccine will also involve an important and powerful component called the complement system. This has profound consequences for the risk-benefit analysis of the vaccines.

Key papers behind these recent developments are:

1. Ogata et al. [15] showing that the SARS-CoV-2 spike protein circulates in the bloodstream shortly after vaccination with mRNA vaccine. This constitutes compelling evidence that spike protein molecules are produced by cells that are in contact with the bloodstream. The endothelial cells lining blood vessel walls naturally represent prime candidates.

2. Amanat et al. [16], Ogata et al. [15], and Wisnewski et al. [17], who found that circulating SARS-CoV-2-specific IgG and IgA antibodies became detectable within 1-2 weeks after mRNA vaccination. This early response indicates immunological memory—it can only be elicited through re-stimulation of pre-existing immune cells.
3. Gallais et al. [18], who provided data consistent with a memory-type antibody response in over 99% of people studied following first contact with the SARS-CoV-2 virus.
4. Wisnewski et al. [17], who reported a very rapid increase of spike protein antibodies after the second injection of mRNA vaccines. This finding underscores the immediate dangers of revaccination.
5. Magro et al. [19,20] showing that following entry into the bloodstream, spike protein directs complement attack to the inner vessel lining, causing damage and leakiness of the blood vessels

An explanation of the underlying immunology for laypeople follows.

2.2. Updated Immune Profile of COVID-19 and its Vaccines

Importantly for COVID-19 vaccination, the 2021 discoveries reveal that the SARS-CoV-2 virus responsible for COVID-19 is not truly new to our immune systems. The finding that the overwhelming majority of people show a memory-type antibody profile to COVID-19 vaccines proves that our immune systems have seen viruses similar to SARS-CoV-2 before. As a result, our bodies have stored an immune memory of that family of viruses, equipping us to fight back more rapidly and powerfully the next time we encounter a similar virus again. As SARS-Cov-2 is of the coronavirus family, this indicates that we possess lasting cross-immunity from previous exposure to other coronaviruses, such as common cold coronaviruses, which are in wide circulation globally. Simply put, almost anyone who is fundamentally healthy—or ‘immunocompetent’—is naturally sufficiently protected against COVID-19.

This immunological status accords with the well-documented reality that the infection fatality rate for COVID-19 is 0.15-0.2% worldwide [12–14]. As is well known, COVID-19 infection runs a fatal course only in those who are weakened by age and significant comorbidity. Put differently, once infected, COVID-19 is non-lethal to >99.8% of the world’s population. This same figure is upwards of 99.9% in the young and middle-aged. These statistics reflect the fact that protective cross-immunity is the global norm.

2.3. A Word on “Cases”

But what about the second and third waves of “cases”, including from Delta and other variants, around the world?

It is important to understand that a COVID-19 “case”, as currently defined, does not correspond to being ill. To an unprecedented extent in medical history, rather than referring to actual disease, the term “case” has become conflated with nothing more than a positive Polymerase Chain Reaction (PCR) test result. While PCR tests are useful in laboratory research and as diagnostic tools when carefully performed, they are not reliable or appropriate when used in isolation, nor set at extremely high sensitivities, nor in poorly trained hands, as has been the case overwhelmingly for COVID-19.

It has long been known that reliance on PCR tests alone to define medical “cases” and causes of death results in “overdiagnosis, overtreatment, and increased health care costs” [21]. If PCR alone were used to diagnose an infection with the diarrhoeal pathogen Clostridium difficile (CD), for instance, an epidemic of CD would immediately appear. We would find, based on PCR results, that 50% of people in long term care, and 15% of those hospitalised for any reason, are CD “cases” [22]. Should they die of any cause

following a positive PCR test for CD, they would be recorded as “dying with” CD. That figure could conceivably approach 100% if PCR tests were performed at the high sensitivities, or cycle thresholds, routinely employed when testing for COVID-19, in which the sensitivity of the test has been dialled up to meaningless extremes [23].

Moreover, even if we accepted PCR alone as a diagnostically appropriate tool—and therefore the high number of “cases” that it generates—we would still necessarily infer a very low infection fatality rate for COVID-19. This supports rather than contradicts the reality that SARS-CoV-2 poses no significant threat to the immunocompetent. In short, thanks to population immunity, for the vast majority of us, a “case” does not equate to severe disease.

2.4. Four Immunological Problems with COVID-19 Vaccines

While the now clearly established widespread cross-immunity against SARS-CoV-2 implies that most of us are safe from severe COVID-19 disease, it also means that we are vulnerable to the harms of gene-based vaccines. Due to recall immunity against the virus, vaccination will cause our immune systems to fight aggressively against not only the SARS-CoV-2 spike protein, but against ourselves. This deleterious autoimmune attack must be expected to intensify with each repeated injection.

The COVID-19 vaccine technology’s interaction with the immune system creates the following four specific problems:

1. Flying under the immune system’s radar with the vaccine’s genetic code
2. Delivering the spike protein into the bloodstream
3. Inducing immune attack on the blood vessel lining
4. Enhancing the severity of natural infection

2.4.1. Flying Under the Immune System’s Radar with the Vaccine’s Genetic Code

To understand why COVID-19 vaccine technology is dangerous, it is necessary to first understand how the gene-based vaccines differ from traditional vaccination methods.

A conventional viral vaccine can be a live virus strain derived from the pathogenic virus that has been *attenuated* through one or more genetic mutations, or it can consist of chemically inactivated virus particles that are no longer able to infect any cells. In both cases, protein antigens will be exposed on the surface of the vaccine particles, which can be recognized by antibodies once these have been formed.

COVID-19 vaccines, on the other hand, are not protein antigens but the genetic blueprint for the SARS-CoV-2 spike protein antigen. That blueprint comes in the form of mRNA or DNA, which, after vaccination, enters our body’s cells and instructs those cells to manufacture the spike protein. The spike protein then protrudes from the cell and induces antibody formation. In response, the immune system will react not only with the spike protein, but will attack and try to destroy the entire cell.

If we are injected with a traditional live virus vaccine to which we have no immunity, then these vaccine virus particles will also infect some of our body cells and propagate within them. Two kinds of immune reactions will then occur:

1. Cytotoxic T-lymphocytes (killer T-cells) (see section 2.4.3.1) that recognize viral protein fragments associated with the infected cells will proliferate, attack, and destroy the infected cells.
2. B-lymphocytes that recognize viral proteins (see section 2.4.3.2) will proliferate and start producing antibodies—soluble protein molecules that can recognize and neutralize virus particles.

This immune reaction will in principle resemble that to an infection with the corresponding wild-type virus. It will be milder, since the vaccine strain of the virus has been attenuated; however, some cells will get destroyed in the process, which may sometimes cause functional organ damage. Live virus vaccines therefore tend to be more prone to adverse reactions than are inactivated virus vaccines.

Now, a key point to note is that if we inject a live traditional vaccine into a person who is already immune—due to either a previous vaccination, or to prior infection with the corresponding wild-type virus—the extent of cell destruction will be much reduced. Such a person will already have antibodies to the virus; these will recognize the viral protein antigens and will bind and inactivate most of the vaccine virus particles before they manage to infect a cell. Therefore, even though the killer T-cells may be all riled up, they will not find very many infected cells to pounce on.

The crucial difference between a conventional live virus vaccine and a gene-based COVID vaccine—and in particular an mRNA vaccine—is that the latter contains no protein antigens whatsoever; instead, it only contains the blueprint for their synthesis inside the infected cells. Therefore, if such a vaccine is injected into a person with antibodies and existing T-cell immunity, the vaccine particles will "fly under the radar" of the antibody defence and reach our body cells unimpeded. The cells will then produce the spike protein, and subsequently be destroyed and attacked by the killer T-cells. The antibodies, rather than preventing the carnage, will join in by also binding to the cell-associated spike protein and directing the complement system (see later) and other immune effector mechanisms against these cells. In a nutshell, pre-existing immunity mitigates the risk of conventional vaccines, but it amplifies the risk of gene-based vaccines.

Importantly, before COVID, this risky gene-based vaccine technology had never before been used on a wide scale against infectious disease and is inherently experimental. The COVID-19 vaccination program is thus the largest human experiment ever performed in history.

2.4.2. Delivering the Spike Protein into the Bloodstream

A dire danger of COVID-19 vaccines is that spike proteins produced by myriad endothelial cells, i.e. the innermost cells lining blood vessel walls, will be exported to the cell surface and protrude directly into the bloodstream. Moreover, a fraction of these spikes will be cleaved during their passage to the outside world. They will fall off the cells into the bloodstream and then bind to their receptors on other endothelial cells at distant sites.

While at the outset of the vaccination campaign in 2020 it was unknown to what extent COVID vaccines entered the bloodstream, human data from 2021 reveal that the spike protein shows up within the circulation on the very day of the injection [15]. Similarly, animal studies submitted by Pfizer to the Japanese government [24] found that the vaccine appears in the circulation within 15 minutes of intramuscular injection, reaching maximum plasma concentration within just two hours. Very high levels have subsequently been recorded in the liver, the spleen, the adrenal glands, and the ovaries. Vaccine components have also been observed in the central nervous system (the brain and the spinal cord), albeit at lower concentrations. Such widespread distribution throughout the body via the bloodstream is a feat that the SARS-CoV-2 virus does not usually achieve.

2.4.2.1. Open Questions in the Ongoing Experiment

But how do COVID-19 vaccine particles enter the circulation in the first place? The vaccine is injected intramuscularly, and the vaccine particles are too large to passively diffuse across blood vessel walls. Most obviously, the vaccines will follow the conventional, relatively time-consuming path which takes them via the draining lymph nodes to the blood circulation. But additionally, two possibilities for very rapid entry

into the bloodstream should be heeded. The first is via direct uptake by vessels that are damaged during insertion of the needle. Secondly, it is possible that the vaccine particles undergo 'transcytosis', a process that enables large molecules to be transported across intact cell layers. Whatever the case may be, although Pfizer knew before the onset of clinical trials that their vaccine reached the bloodstream rapidly, either they failed to file these findings with medical regulators in Europe, the US and other Western countries, or the regulators failed to act upon the findings [25].

This is a critical oversight where patient safety is concerned. Given that the gene-based vaccines induce the body's cells to become immune targets, where in the body this takes place is of critical concern. While immune-mediated cell death is never favourable, it is particularly detrimental and dangerous if it afflicts the blood vessel walls.

2.4.3. Attacking the Vessel Walls: Clotting and Leaky Vessels

While all vaccines seek to stimulate an immune response, not all immune responses are created equal. Some are safe and well-modulated whereas others can be misdirected and out of control. Immune responses are problematic when they attack the self, as in autoimmune conditions, and/or when they are excessively intense and severe.

COVID-19 vaccines incur problematic immunity in both key ways. First, they can be expected mobilise a self-to-self immune response against the endothelial cells lining blood vessel walls. Second, by boosting SARS-CoV-2 immunity, they can be expected to incite an increasingly aggressive response with each administration of the vaccine.

To understand the realities of these processes it is necessary to first understand the basics of the underlying immune response. There are three key components of the immune system relevant to risks from COVID-19 vaccines: T-cells, antibodies and the complement cascade.

2.4.3.1. T-cells

Once the body's cells have been infected with a virus, immune cells known as cytotoxic T-cells or T-killer cells attack and destroy the infected cells. This prevents infected cells from replicating the virus and spreading the infection throughout the body. After the initial battle with a certain pathogen is over, some of the specifically adapted T-cells enter a state of dormancy to become memory T-cells. In case the same virus is encountered again, these dormant T-cells can be swiftly reawakened and propagated to mount a faster and more vigorous response next time. Known as a secondary or memory-type response, it will also occur with viruses that are not exactly the same as the one initially encountered but sufficiently similar to be recognised. This latter phenomenon is referred to as cross-immunity.

It has been known since mid 2020 that we are protected against SARS-CoV-2 by cross-reactive memory T-cells [7–11]. As with antibodies, this is based on previous encounters with common cold coronaviruses, and with the SARS virus in a small number of people. Such prior experience has been found to confer "robust" [7] and lasting T-cell cross-immunity to COVID-19. T-cell memory for the SARS virus is known to last at least 17 years [7], but it likely lasts a lifetime.

2.4.3.2. Antibodies

Before the new discoveries of 2021, scientists' concerns about clotting and bleeding were based primarily on the prediction that killer T-cells would attack spike-producing endothelial cells, causing lesions on

vessel linings and promoting blood clots. While this mechanism remains valid, we now know that a memory-type antibody response will join the attack on the vessel walls as well.

Whereas killer T-cells attack their targets cell-to-cell, antibodies are proteins that exert their effect by binding to signature structures on the pathogen's surface, known as epitopes. Instead of destroying cells directly, once attached to an epitope, antibodies help to defeat invaders by "calling out the cavalry" on infected cells.

This leads to the second process by which cells coated with viral spikes will inadvertently come under immune attack. "Calling out the cavalry" means that the antibodies attached to the unnaturally created spikes will trigger activation of the complement system, which thereupon will mount a massive attack on the endothelial cells.

Importantly for deciphering the recent discoveries on SARS-CoV-2 immunity, the first time that the immune system encounters a new pathogen, new antibodies in a shape capable of binding to that pathogen's epitopes must be formed (by immune cells known as B-cells). First-time antibody production is slow, taking approximately four weeks. Should the same pathogen or family of pathogens invade again, however, memory-type antibodies are then manufactured more rapidly, within one to two weeks. This is a cardinal sign that the immune system has seen that pathogen before.

Another defining feature of a memory antibody response concerns the order in which antibody sub-types are produced. If a pathogen is new, IgM is the first type of antibody to arrive on the scene. It is followed later by IgG and IgA. The next time the pathogen arrives, however, IgG and IgA will be the first to arrive, indicating that the virus, or its relatives, have invaded before.

Importantly, this is precisely what we see with COVID-19.

Several research groups found in 2021 that upon first exposure to SARS-CoV-2, and following COVID-19 vaccination, the antibody response was characteristic of the memory type, due both to the timing and nature of antibodies measured. [xv-xvii] As a result, we now know that our immune systems recognise SARS-CoV-2 at first sight, even "on the slightest viral challenge" [5]. In other words, SARS-CoV-2 is not a novel coronavirus after all.

With respect to variants and the need for booster shots, memory B-cells, like memory T-cells, can recognise not only a specific virus, but a whole family of viruses bearing related epitopes. It is unsurprising, therefore, that memory B-cells recognise SARS-CoV-2 from the common cold. With cross immunity this robust, closer relatives of SARS-CoV-2 in the form of variants will pose no obstacle to our antibody response. The rising "cases", hospitalisations and deaths attributed to Delta and other variants are therefore almost certainly driven by false positive PCR results and misclassification than by a true increase in COVID-19 disease. Indeed, according to Public Health England data, the Delta variant is non-lethal in those under 50, and less than half as lethal as earlier strains in older age groups [26].

But why haven't circulating antibodies to SARS-CoV-2 been detected in populations before? The answer is that neither the antibodies nor T-cells associated with a memory-type response circulate in the bloodstream. Once they are no longer needed, they become dormant, existing as a memory alone. Unless elicited by re-exposure to a virus, they remain invisible in the bloodstream. The dormant antibodies will, however, be ready and waiting to re-activate and call out the cavalry on the spike protein, in the form of the complement cascade.

2.4.3.3. Complement

Recent findings indicate that complement activation is a serious concern with respect to COVID-19 vaccine-immune interactions.

In light of the newly characterised antibody response to SARS-CoV-2, when antibodies attach to spike-producing endothelial cells on vessel walls following vaccine administration, activated complement proteins can be expected attach to the endothelial cells, and perforate their cell membranes [27,28]. The ensuing death of the endothelial cells will expose the tissue underneath the epithelium, which will initiate two significant events. It will induce blood clotting, and will cause the vessel walls to leak [6]. This pathogenic mechanism has been documented in biopsies taken from SARS-CoV-2-infected patients [19,29]. Those studies have described a "catastrophic microvascular injury syndrome mediated by activation of complement" [29] as part of the SARS-CoV-2 spike protein immune response. It is precisely this immune response that COVID-19 vaccines seek to induce.

Such vaccine-immune interactions are consistent with adverse events involving visible capillary rupture under the skin that have been documented and reported following COVID-19 vaccination [30–33].

2.4.3.4. Leaky Vessels—The Promise of Booster Shots

Given that booster shots repeatedly boost the immune response to the spike protein, they will progressively boost self-to-self immune attack, including boosting complement-mediated damage to vessel walls.

Clinically speaking, the greater the vessel leakage and clotting that subsequently occurs, the more likely that organs supplied by the affected blood flow will sustain damage. From stroke to heart attack to brain vein thrombosis, the symptoms can range from death to headaches, nausea and vomiting, all of which heavily populate adverse reactions to COVID-19 vaccines [2].

As well as damage from leakage and clotting alone, it is additionally possible that the vaccine itself may leak into surrounding organs and tissues. Should this take place, the cells of those organs will themselves begin to produce spike protein, and will come under attack in the same way as the vessel walls. Damage to major organs such as the lungs, ovaries, placenta and heart can be expected ensue, with increasing severity and frequency as booster shots are rolled out.

2.4.4. Enhancing the Severity of Wild Coronavirus Infection

Finally, as with the Dengue virus and several other viruses [34], antibodies to coronaviruses can ultimately aggravate rather than mitigate illness. This is called antibody-dependent enhancement of disease. The underlying mechanisms remain to be elucidated but it is already clear that the net effects are severely detrimental.

Attempts to develop vaccines to the original SARS virus, which is closely related to SARS-CoV-2, repeatedly failed due to antibody-dependent enhancement of disease [35–37]. The vaccines induced antibodies, but when the vaccinated animals were subsequently infected with the wild-type virus, they became more ill than the unvaccinated animals, in some cases mortally so [38].

3. Implications for Doctors and Patients

Although vaccine manufacturers and regulators are aware of the risks of antibody enhancement of disease, this possibility was not adequately addressed in the clinical trials on any of the COVID-19 vaccines. The

FDA noted that Pfizer, “identified vaccine-associated enhanced disease, including vaccine-associated enhanced respiratory disease, as an important potential risk” [23]. The EMA similarly acknowledged that “vaccine associated enhanced respiratory disease” was “an important potential risk… that may be specific to vaccination for COVID- 19”.

Why neither regulator sought to exclude such dangers prior to emergency use authorisation is an open question that all doctors and patients are entitled to ask. Why medical regulators failed to investigate the finding that large vaccine particles cross blood vessel walls, entering the bloodstream and posing risks of blood clotting and leaky vessels is yet another open question again.

The fact that vaccine rollout began before the immune profile of SARS-CoV-2 and COVID-19 vaccines had been adequately delineated is symptomatic of a rushed and highly politicised approach to the approval and regulation of COVID-19 vaccines. As is the lack of clinical trials investigating the safety of COVID-19 booster shots.

In this context, it is up to doctors and patients to uphold the social contract of the doctor-patient relationship, and take medical prudence and patient safety into their own hands.

The World Medical Association, Declaration of Geneva, Physician’s Pledge states [39]:

“The health and wellbeing of my patient will be my first consideration. I will maintain the utmost respect for human life. I will practise my profession with conscience and dignity and in accordance with good medical practice. I will respect the autonomy and dignity of my patient. I will not use my medical knowledge to violate human rights and civil liberties, even under threat.”

References

1. Open VAERS, (2021) VAERS COVID vaccine data.
2. Open VAERS, (2021) All deaths reported to VAERS by year
3. Doctors for Covid Ethics, (2021) Doctors for COVID Ethics: letters.
4. Doctors for Covid Ethics, (2021) Rebuttal letter to European Medicines Agency from Doctors for Covid Ethics, April 1, 2021.
5. Bhakdi, S. et al. (2021) Letter to Physicians: Four New Scientific Discoveries Regarding COVID-19 Immunity and Vaccines—Implications for Safety and Efficacy.
6. Doctors for Covid Ethics, (2021) Leaky Blood Vessels: An Unknown Danger of COVID-19 Vaccination.
7. Le Bert, N. et al. (2020) SARS-CoV-2-specific T cell immunity in cases of COVID-19 and SARS, and uninfected controls. *Nature* 584:457-462
8. Tarke, A. et al. (2021) Impact of SARS-CoV-2 variants on the total CD4+ and CD8+ T cell reactivity in infected or vaccinated individuals. *Cell reports. Medicine* 2:100355
9. Grifoni, A. et al. (2020) Targets of T Cell Responses to SARS-CoV-2 Coronavirus in Humans with COVID-19 Disease and Unexposed Individuals. *Cell* 181:1489-1501.e15
10. Mateus, J. et al. (2020) Selective and cross-reactive SARS-CoV-2 T cell epitopes in unexposed humans. *Science* 370:89-94
11. Sekine, T. et al. (2020) Robust T Cell Immunity in Convalescent Individuals with Asymptomatic or Mild COVID-19. *Cell* 183:158-168.e14
12. Ioannidis, J.P.A. (2020) Infection fatality rate of COVID-19 inferred from seroprevalence data. *Bull. World Health Organ.* -:BLT.20.265892

13. Ioannidis, J.P.A. (2020) Global perspective of COVID-19 epidemiology for a full-cycle pandemic. *Eur. J. Clin. Invest.* 50:x-x
14. Ioannidis, J.P.A. (2021) Reconciling estimates of global spread and infection fatality rates of COVID-19: An overview of systematic evaluations. *Eur. J. Clin. Invest.* 5:e133554
15. Ogata, A.F. et al. (2021) Circulating SARS-CoV-2 Vaccine Antigen Detected in the Plasma of mRNA-1273 Vaccine Recipients. *Clin. Infect. Dis.* -:x-x
16. Amanat, F. et al. (2021) SARS-CoV-2 mRNA vaccination induces functionally diverse antibodies to NTD, RBD and S2. *Cell* -:x-x
17. Wisnewski, A.V. et al. (2021) Human IgG and IgA responses to COVID-19 mRNA vaccines. *PLoS One* 16:e0249499
18. Gallais, F. et al. (2021) Intrafamilial Exposure to SARS-CoV-2 Associated with Cellular Immune Response without Seroconversion. *Emerg. Infect. Dis.* 27:x-x
19. Magro, C.M. et al. (2020) Docked severe acute respiratory syndrome coronavirus 2 proteins within the cutaneous and subcutaneous microvasculature and their role in the pathogenesis of severe coronavirus disease 2019. *Hum. Pathol.* 106:106-116
20. Magro, C.M. et al. (2021) Severe COVID-19: A multifaceted viral vasculopathy syndrome. *Annals of diagnostic pathology* 50:151645
21. Polage, C.R. et al. (2015) Overdiagnosis of Clostridium difficile Infection in the Molecular Test Era. *JAMA internal medicine* 175:1792-801
22. Anonymous, (2021) Overdiagnosis of Clostridium difficile.
23. Palmer, M. et al. (2021) Expert evidence regarding Comirnaty (Pfizer) COVID-19 mRNA Vaccine for children.
24. Anonymous, (2020) SARS-CoV-2 mRNA Vaccine (BNT162, PF-07302048) 2.6.4 Summary statement of the pharmacokinetic study [English translation].
25. Palmer, M. and Bhakdi, S. (2021) The Pfizer mRNA vaccine: Pharmacokinetics and Toxicity.
26. Public Health England, (2021) SARS-CoV-2 variants of concern and variants under investigation in England.
27. Bhakdi, S. and Tranum-Jensen, J. (1978) Molecular nature of the complement lesion. *Proc. Natl. Acad. Sci. U. S. A.* 75:5655-5659
28. Tranum-Jensen, J. et al. (1978) Complement lysis: the ultrastructure and orientation of the C5b-9 complex on target sheep erythrocyte membranes. *Scandinavian journal of immunology* 7:45-6
29. Magro, C. et al. (2020) Complement associated microvascular injury and thrombosis in the pathogenesis of severe COVID-19 infection: A report of five cases. *Transl Res* 220:1-13
30. Greinacher, A. et al. (2021) Thrombotic Thrombocytopenia after ChAdOx1 nCov-19 Vaccination. *N. Engl. J. Med.* -:x-x
31. Lee, E. et al. (2021) Thrombocytopenia following Pfizer and Moderna SARS-CoV-2 vaccination. *Am. J. Hematol.* -:x-x
32. Malayala, S.V. et al. (2021) Purpuric Rash and Thrombocytopenia After the mRNA-1273 (Moderna) COVID-19 Vaccine. *Cureus* 13:e14099
33. Tarawneh, O. and Tarawneh, H. (2021) Immune thrombocytopenia in a 22-year-old post Covid-19 vaccine. *Am. J. Hematol.* 96:E133-E134
34. Tirado, S.M.C. and Yoon, K. (2003) Antibody-dependent enhancement of virus infection and disease. *Viral immunology* 16:69-86
35. Tseng, C. et al. (2012) Immunization with SARS coronavirus vaccines leads to pulmonary immunopathology on challenge with the SARS virus. *PLoS One* 7:e35421

36. Weingartl, H. et al. (2004) Immunization with modified vaccinia virus Ankara-based recombinant vaccine against severe acute respiratory syndrome is associated with enhanced hepatitis in ferrets. *J. Virol.* 78:12672-6
37. Czub, M. et al. (2005) Evaluation of modified vaccinia virus Ankara based recombinant SARS vaccine in ferrets. *Vaccine* 23:2273-9
38. Bolles, M. et al. (2011) A double-inactivated severe acute respiratory syndrome coronavirus vaccine provides incomplete protection in mice and induces increased eosinophilic proinflammatory pulmonary response upon challenge. *J. Virol.* 85:12201-15
39. World Medical Association, (2017) WMA Declaration of Geneva.

We For Humanity

We are an international association of lawyers, doctors, scientists, journalists as well as representatives of other professions.

We represent interests of all people in the world who aspire to live in freedom, self-determination, dignity and truthfulness.

SENT TO:

EMA, EU
MHRA, UK
TGA, Australia,
Medsafe, New Zealand
FMRAC, Canada
AHPRA, Australia

STOP HOLOCAUST

Ladies and Gentlemen,

We, the survivors of the atrocities committed against humanity during the Second World War, feel bound to follow our conscience and write this letter.

It is obvious to us that another holocaust of greater magnitude is taking place before our eyes. The majority of the world's populace do not yet realize what is happening, for magnitude of an organized crime such as this is beyond their scope of experience. We, however, know. We remember the name Josef Mengele. Some of us have personal memories. We experience a déjà vu that is so horrifying that we rise to shield our poor fellow humans. The threatened innocents now include children, and even infants.

In just four months, the COVID-19 vaccines have killed more people than all available vaccines combined from mid-1997 until the end of 2013 — a period of 15.5 years. And people affected worst are between 18 and 64 years old – the group which was not in the Covid statistics.

We call upon you to stop this ungodly medical experiment on humankind immediately.

What you call "vaccination" against SARS-Cov-2 is in truth a blasphemic encroachment into nature. Never before has immunization of the entire planet been accomplished by delivering a synthetic mRNA into the human body. It is a medical experiment to which the Nuremberg Code must be applied. The 10 ethical principles in this document represents a foundational code of medical ethics that was formulated during the Nuremberg Doctors Trial to ensure that human beings will never again be subjected to involuntary medical experimentation & procedures.

Principle 1 of the Nuremberg Codex:

> **(a)** ***"The voluntary consent of the human subject is absolutely essential.*** *This means that the person involved should have legal capacity to give consent; should be so situated as to be able to exercise free power of choice, without the intervention of any element of force, fraud, deceit, duress, overreaching, or other*

ulterior form of constraint or coercion; and should have sufficient knowledge and comprehension of the elements of the subject matter involved as to enable him to make an understanding and enlightened decision. **(b)** *This latter element requires that before the acceptance of an affirmative decision by the experimental subject there should be made known to him the nature, duration, and purpose of the experiment; the method and means by which it is to be conducted; all inconveniences and hazards reasonably to be expected; and the effects upon his health or person which may possibly come from his participation in the experiment.* **(c)** *The duty and responsibility for ascertaining the quality of the consent rests upon each individual who initiates, directs, or engages in the experiment. It is a personal duty and responsibility which may not be delegated to another with impunity*.

Re. (a): There is no question of a free decision. Mass media spread fear and panic and use the rule of Goebbels' propaganda by repeating untruths until they are believed. For weeks now they have been calling for the ostracism of the unvaccinated. If 80 years ago it was the Jews who were demonized as spreaders of infectious diseases, today it is the unvaccinated who are being accused of spreading the virus. Physical integrity, freedom to travel, freedom to work, all coexistence has been taken away from people in order to force vaccination upon them. Children are being enticed to get vaccinated against their parents' judgement.

Re (b): The 22 terrible side effects already listed in the FDA emergency use authorization were not disclosed to the subjects of the experimental trial. We list those below to the benefit of the world public.

By definition, there has never been informed consent. In the meantime, thousands of side effects recorded in numerous databases are on record. While the so-called case numbers are being bleeped in 30-min-intervals by all mass media, there is neither any mentioning of the serious adverse side effects nor how and where the side effects are to be reported. As far as we know, even recorded damages have been deleted on a large scale in every database.

Principle 6 of the Nuremberg Code requires: "*The degree of risk to be taken should never exceed that determined by the humanitarian importance of the problem to be solved by the experiment*".

"Vaccination" against Covid has proven to be more dangerous than Covid for approximately 99% of all humans. As documented by Johns Hopkins, in a study of 48,000 children, children are at zero risk from the virus. Your own data shows that children who are at no risk from the virus, have had heart attacks following vaccination; more than 15,000 have suffered adverse events – including more than 900 serious events. At least 16 adolescents have died following vaccination in the USA. As you are aware, just around 1% are being reported. And the numbers are increasing rapidly as we write. With your knowledge.

Principle 10 of the Code: "*During the course of the experiment, the scientist in charge must be prepared to terminate the experiment at any stage, if he has probable cause to believe, in the exercise of the good faith, superior skill and careful judgment required of him, that a continuation of the experiment is likely to result in injury, disability, or death to the experimental subject.*"

Allegedly around 52% of the world population has received at least one shot.

Honest disclosure of the true number of “vaccine” injured, terminally injured as well as deceased worldwide is long overdue. These are millions in the meantime. Provide us with the true numbers of Covid vaccine casualties now.

How many will be enough to awaken your conscience?

List of adverse effects being known to FDA before the emergency approval

1. Guillain-Barré syndrome
2. Acute disseminated encephalomyelitis
3. Transverse myelitis
4. Encephalitis/encephalomyelitis/meningoencephalitis/meningitis/encepholapathy
5. Convulsions/seizures
6. Stroke
7. Narcolepsy and cataplexy
8. Anaphylaxis
9. Acute myocardial infraction
10. Myocarditis/pericarditis
11. Autoimmune disease
12. Deaths
13. Pregnancy and birth outcomes
14. Other acute demyelinating diseases
15. Non-anaphylactic allergic reactions
16. Thrombocytopenia
17. Disseminated intravascular coagulation
18. Venous thromboembolism
19. Arthritis and arthralgia/joint pain
20. Kawasaki disease
21. Multisystem inflammatory syndrome in CHILDREN
22. Vaccine enhanced disease.

Signed

Concentration Camp survivors, their sons, and daughters, and grandchildren, including persons of goodwill and conscience.

According to present consents:

Rabbi Hillel Handler

Hagar Schafrir

Sorin Shapira

Mascha Orel

Morry Krispijn

Shimon Yanowitz

Hila Moscovich

Tamir Turgal

Amira Segal

Jacqueline Ingenhoes

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